

English

For FIELD-BASED SERVICES ONLY
Los Angeles County - Department of Mental Health

**Adult /
Older Adult
MHSIP
Survey**

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you receive. For each survey item, please fill in the circle that corresponds to your choice. Please fill in the circle completely.

Example: ● Correct ⊗ ⊖ ⊙ Incorrect

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1 The location of services was convenient (parking, public transportation, distance, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 Staff were willing to see me as often as I felt was necessary.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3 Services were available at times that were good for me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 Staff were sensitive to my cultural background (race, religion, language, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 I deal more effectively with daily problems.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 I do better in school and/or work.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 My symptoms are not bothering me as much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Birthdate							
Month		Date		Year			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	1	9	<input type="text"/>	<input type="text"/>

What is your gender?	
<input type="radio"/>	Female
<input type="radio"/>	Male
<input type="radio"/>	Other

Are you of Mexican / Hispanic / Latino origin?	
<input type="radio"/>	Yes
<input type="radio"/>	No
<input type="radio"/>	Unknown

What is your race?			
(Please mark all that apply)			
<input type="radio"/>	American Indian/ Alaskan Native	<input type="radio"/>	Native Hawaiian / Other Pacific Islander
<input type="radio"/>	Asian	<input type="radio"/>	White / Caucasian
<input type="radio"/>	Black / African American	<input type="radio"/>	Other
		<input type="radio"/>	Unknown

FOR OFFICE USE ONLY

Client MIS/IS Number						
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Clinic IS Number			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Service Area
<input type="text"/>

Reason	
<input type="radio"/>	REFUSED
<input type="radio"/>	IMPAIRED
<input type="radio"/>	LANG
<input type="radio"/>	OTHER

MAY 2009

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